

13830 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Daniels				c. LENGTH OF STAY IN 1b X Daniels			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CINDY Middle CHURCH Last CHURCH				4. DATE OF DEATH Month 12 Day 20 Year 1958			
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20 1893	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6 Days 20 Hours 12 Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Cotton Mill		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Andes				14. MOTHER'S MAIDEN NAME Trivett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-20 6181		17. INFORMANT Wilton Church, Woodlawn, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DISSEMINATED CARCINOMATOSIS DUE TO (c) CA. OF COLON						INTERVAL BETWEEN ONSET AND DEATH 1 DAY 6 Mos. 1 Yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1957 , 19____, to 12-20 , 19 58 , that I last saw the deceased alive on 12-20 , 19 58 , and that death occurred at 9:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) COLUMBIA RD DATE SIGNED 12-22-58							
ACTUAL SIGNATURE P. V. Thorpe M.D.				PHYSICIAN'S NAME (Type) PETER V. THORPE MD ELlicott City MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-23-58	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE DEC 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13829 CERTIFICATE OF DEATH

13817

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3 Vol-4 ✓	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>4503 Dunland Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TAYLOR MANOR HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dorothy</u> First <u>L.</u> Middle <u>Burnham</u> Last		4. DATE OF DEATH <u>Dec.</u> Month <u>13</u> Day <u>1958</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Crisfield, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas S. Elmore</u>		14. MOTHER'S MAIDEN NAME <u>Aleta Duncan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Records Taylor Manor Hospital</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral edema</u> <u>322.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute alcohol intoxication</u> DUE TO (c) <u>Chronic alcoholism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>approx 3 weeks</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Depression</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>Dec 8</u> , 19 <u>58</u> , to <u>Dec. 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 13</u> , 19 <u>58</u> , and that death occurred at <u>2:28 AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>TAYLOR MANOR HOSPITAL</u>		DATE SIGNED <u> </u>	
ACTUAL SIGNATURE <u>Irving J. Taylor</u> M.D.		PHYSICIAN'S NAME (Type) <u>IRVING J. TAYLOR</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Belts</u> ADDRESS <u>17th St</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
13831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clary Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups d. STREET ADDRESS Clary Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DENNIS Middle ERIC Last DORSEY		4. DATE OF DEATH Month December Day 23 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/58
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Richard Dorsey		14. MOTHER'S MAIDEN NAME Florence Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard Dorsey		Address Jessups, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Interstitial pneumonitis 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/23/58	
22a. BURIAL, CREMATION, REBURY (City) Burial		22b. DATE THEREOF 12/27/58	
22c. NAME OF CEMETERY OR CREMATORY Browns Chapel,		22d. LOCATION (City, town, or county) (State) Dayton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sworden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DEC 30 '58		24b. REGISTRAR'S SIGNATURE Arthur L. House	

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NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE
DEPARTMENT OF HEALTH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

DATE OF DEATH

PLACE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13832 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13820

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SCAGGSVILLE RD</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LAUREL</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET</u> <u>FAIR</u>				4. DATE OF DEATH Month Day Year <u>12</u> <u>11</u> <u>1958</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>UNKNOWN</u>		9. AGE (In years last birthday) <u>83 1/2</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MILDRED DAY</u> Address <u>LAUREL, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIO SCLEROTIC C-V DISEASE</u> (a), stating the underlying cause last. DUE TO (c) <u>CHRONIC</u>												INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NON</u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Donald E. Fisher</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED	
EXAMINER'S NAME (Type) <u>DONALD E. FISHER MD</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												<u>12-11-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Dec 13 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Scaggsville, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Caldwell</u> ADDRESS <u>Laurel, Md</u>						24a. REC'D BY REGISTRAR <u>DEC 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1833 MEDICAL EXAMINER, CERTIFICATE OF DEATH

NAME OF DECEASED
AGE
SEX
OCCUPATION

RESIDENCE
DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH
MANNER OF DEATH

TIME OF DEATH
PLACE OF DEATH

NAME OF PHYSICIAN
NAME OF SURGEON

NAME OF ASSISTANT
NAME OF NURSE

NAME OF WITNESS
NAME OF WITNESS

NAME OF WITNESS
NAME OF WITNESS

NAME OF WITNESS
NAME OF WITNESS

NAME OF WITNESS
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NAME OF WITNESS
NAME OF WITNESS

NAME OF WITNESS
NAME OF WITNESS

13833 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 1 yr-11 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Olga Middle Goldsmith Last Goldsmith		4. DATE OF DEATH Month December Day 14 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/13/78
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady (rtd)	11. BIRTHPLACE (State or foreign country) Germany (Bremen)
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edouard Goldsmith	
14. MOTHER'S MAIDEN NAME Julia (unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 220-18-8283		17. INFORMANT Mrs. Eileen A. Goldsmith - 1701 Eutaw Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalized, severe (c) unknown		INTERVAL BETWEEN ONSET AND DEATH. 72 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome with senile brain disease with psychosis Occultus ulcers			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 12 , 19 57 , to December 14 , 19 58 , that I last saw the deceased alive on Dec. 14 , 19 58 , and that death occurred at 10:15 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving J. Taylor M.D. Taylor Manor Hospital 12/14/58			
ACTUAL SIGNATURE Irving J. Taylor M.D. Taylor Manor Hospital 12/14/58			
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D. Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/58	
22c. NAME OF CEMETERY OR CREMATORY Obah Shalom Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichener & Sons - Balto		24a. REC'D BY REGISTRAR DATE DEC 17 '58	
24b. REGISTRAR'S SIGNATURE Wm. J. Tichener			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is mirrored and appears to be bleed-through from the reverse side of the page.

Vertical text on the right margin, likely a filing or archival note, oriented sideways.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13834 CERTIFICATE OF DEATH

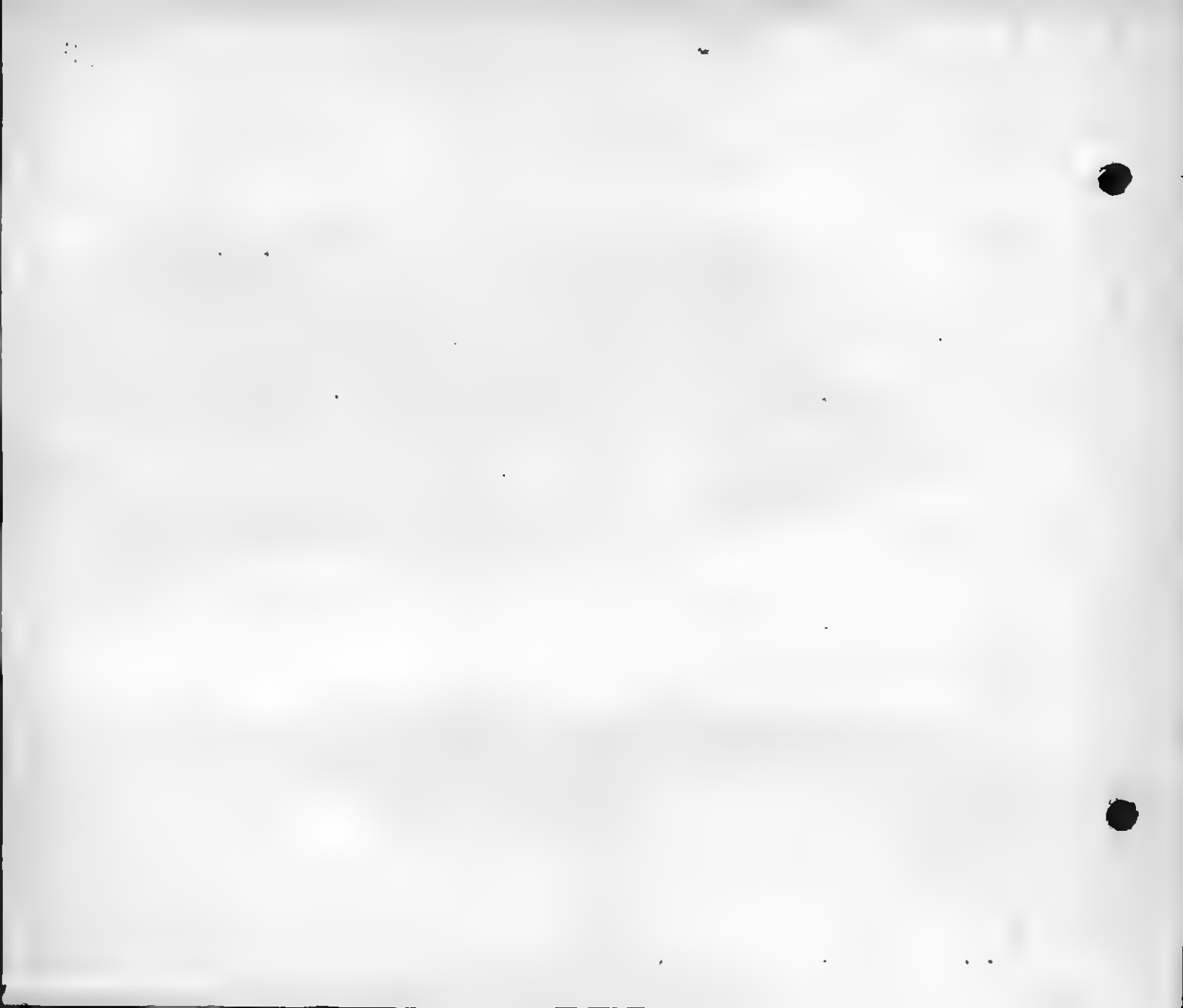
13822

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 Walnut Drive		d. STREET ADDRESS 7 Walnut Drive	
3. NAME OF DECEASED (Type or print) ELIZABETH ALEXINE KING		4. DATE OF DEATH Dec. 30, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trained Nurse		11. BIRTHPLACE (State or foreign country) Leonardtown, Md	
13. FATHER'S NAME Stephen G. King		14. MOTHER'S MAIDEN NAME Isabelle V. Barkley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF COLON DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1958 to March 1959 , that I last saw the deceased alive on March 1959 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald E. Fisher M.D.		ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED Jan 5 1959	
PHYSICIAN'S NAME (Type) Donald E. Fisher M.D.		ELLICOTT CITY MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-2-59	22c. NAME OF CEMETERY OR CREMATORY Meadowridge	22d. LOCATION (City, town, or county) (State) Elkridge, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JAN 5 1959	
		24b. REGISTRAR'S SIGNATURE Wm. S. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13835

CERTIFICATE OF DEATH

13823

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <u>HOWARD CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waterloo</u>		c. LENGTH OF STAY IN 1b <u>Edllicott City P.O. 03X-</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Betty Jane Neuberger</u> First Middle Last		4. DATE OF DEATH <u>12/20/58</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/1/29</u>
9. AGE (In years last birthday) <u>29</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward F. Coney</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Chaffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Thomas P. Neuberger</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X</u> DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>Generalized Carcinoma from left Breast 6 months</u> (b) <u>E. Shull and generalized body metastases</u> (c) <u>E. Shull and generalized body metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>170X</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/6</u> <u>1958</u> , to <u>Dec 20, 1958</u> , that I last saw the deceased alive on <u>Dec 19, 1958</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 EDMONDSON AVE</u> DATE SIGNED <u>12/22/58</u>			
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u>		M.D. <u>EDMONDSON</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>BALTO 29, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mendowridge</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Ratliff & Son</u>		ADDRESS <u>28</u>	
24a. REC'D BY REGISTRAR <u>DEC 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	



1
FOR STATE
HEALTH DEPT.

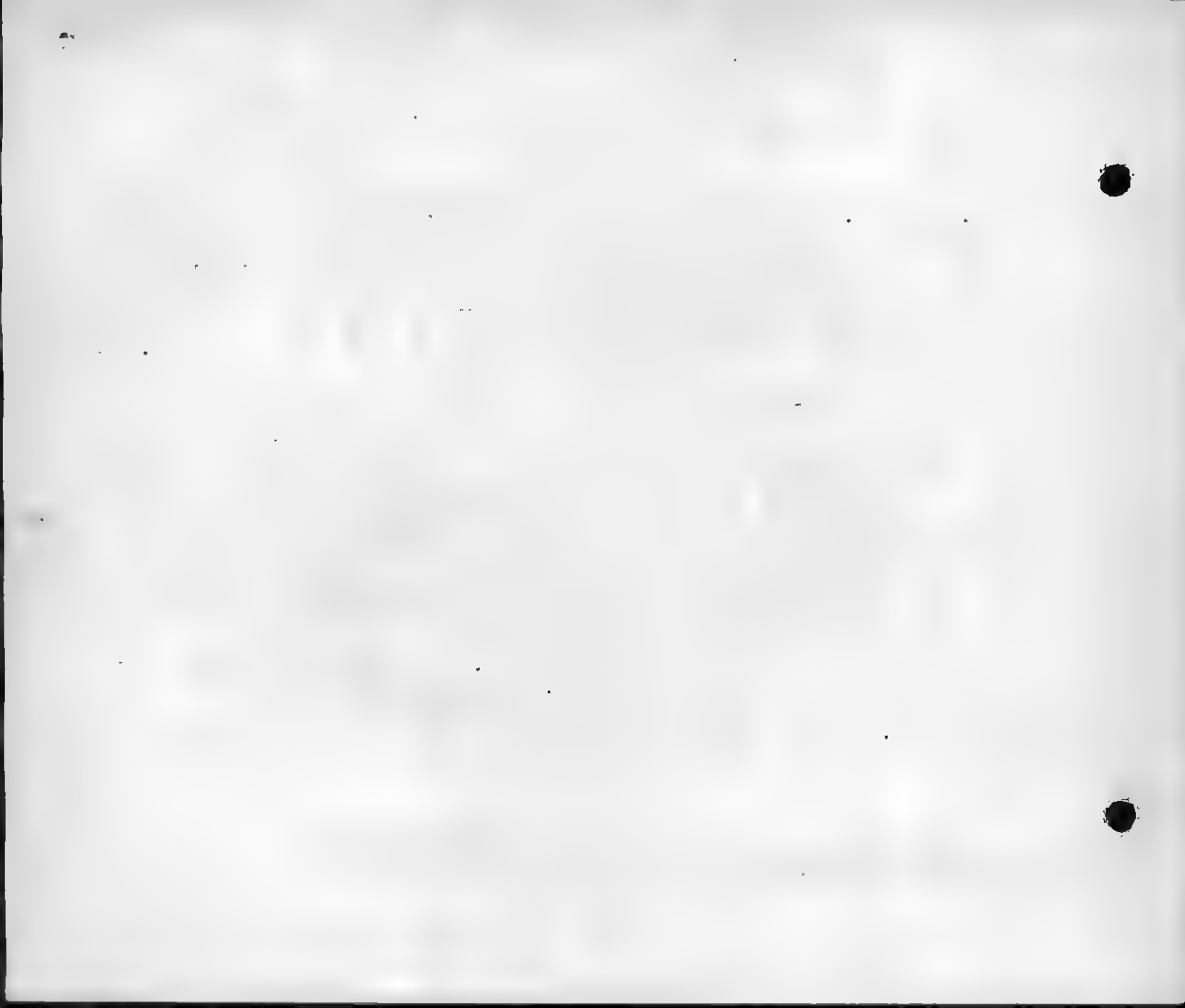
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13836 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/>		d. STREET ADDRESS 2021 E. Lombard St.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GLEN WILLIAM OSBORNE		First		Middle		Last		4. DATE OF DEATH Dec. 13, 1958		Month		Day		Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1-27-20		9. AGE (In years last birthday) 38 yrs		10. IF UNDER 1 YEAR Months		Days		IF UNDER 24 HRS Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stoneman		10b. KIND OF BUSINESS OR INDUSTRY Universal Carloading		11. 8 RTHPLACE (State or foreign country) Possum Creek Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robby Osborne		14. MOTHER'S MAIDEN NAME Ann Slaughter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO.			
17. INFORMANT Alma Osborne		Address 2221 E Baltimore Street		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Eviseration (Traumatic) 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Instant		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Victim going south on Rt. 32 pulled in front of Tractor-Trailer going south on Rt. 1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Victim going south on Rt. 32 pulled in front of Tractor-Trailer going south on Rt. 1		20c. TIME OF INJURY Month, Day, Year P. 4.30 PM 12-13-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Savage		(County) Howard		(State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <i>Donald E. Fisher</i>		EXAMINER'S NAME (Type) Donald E. Fisher		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Ellicott City, Md 12-13-58					
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 18 1958		22c. NAME OF CEMETERY OR CREMATORY East Hill National Cem		22d. LOCATION (City, town, or county) Bristol Tenn-Virginia		22e. (State)		23. FUNERAL DIRECTOR'S SIGNATURE <i>Doppel Bros., Baltimore</i>		ADDRESS Baltimore		24a. REC'D BY REGISTRAR DEC 17 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13837

CERTIFICATE OF DEATH

13825

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville			
				f. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EDMUND Last PARLETT				4. DATE OF DEATH Month Dec. Day 11 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1893	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		11. BIRTHPLACE (State or foreign country) Clarksville, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William D. Parlett				14. MOTHER'S MAIDEN NAME Anna Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Beulah Parlett, Clarksville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS DUE TO (c) HTA 5 CVD				INTERVAL BETWEEN ONSET AND DEATH 1 HR 8 HRS 10 YRS			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov. 19, 1958 to Dec. 9, 1958 , that I last saw the deceased alive on Dec. 9, 1958 , and that death occurred at 7 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ELICOTT CITY DATE SIGNED 12-11-58							
ACTUAL SIGNATURE Peter V. Thorpe M.D.				PHYSICIAN'S NAME (Type) PETER V. THORPE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-13-58		22c. NAME OF CEMETERY OR CREMATORY St. Johns	
22d. LOCATION (City, town, or county) Ellicott City, Md				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE DEC 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

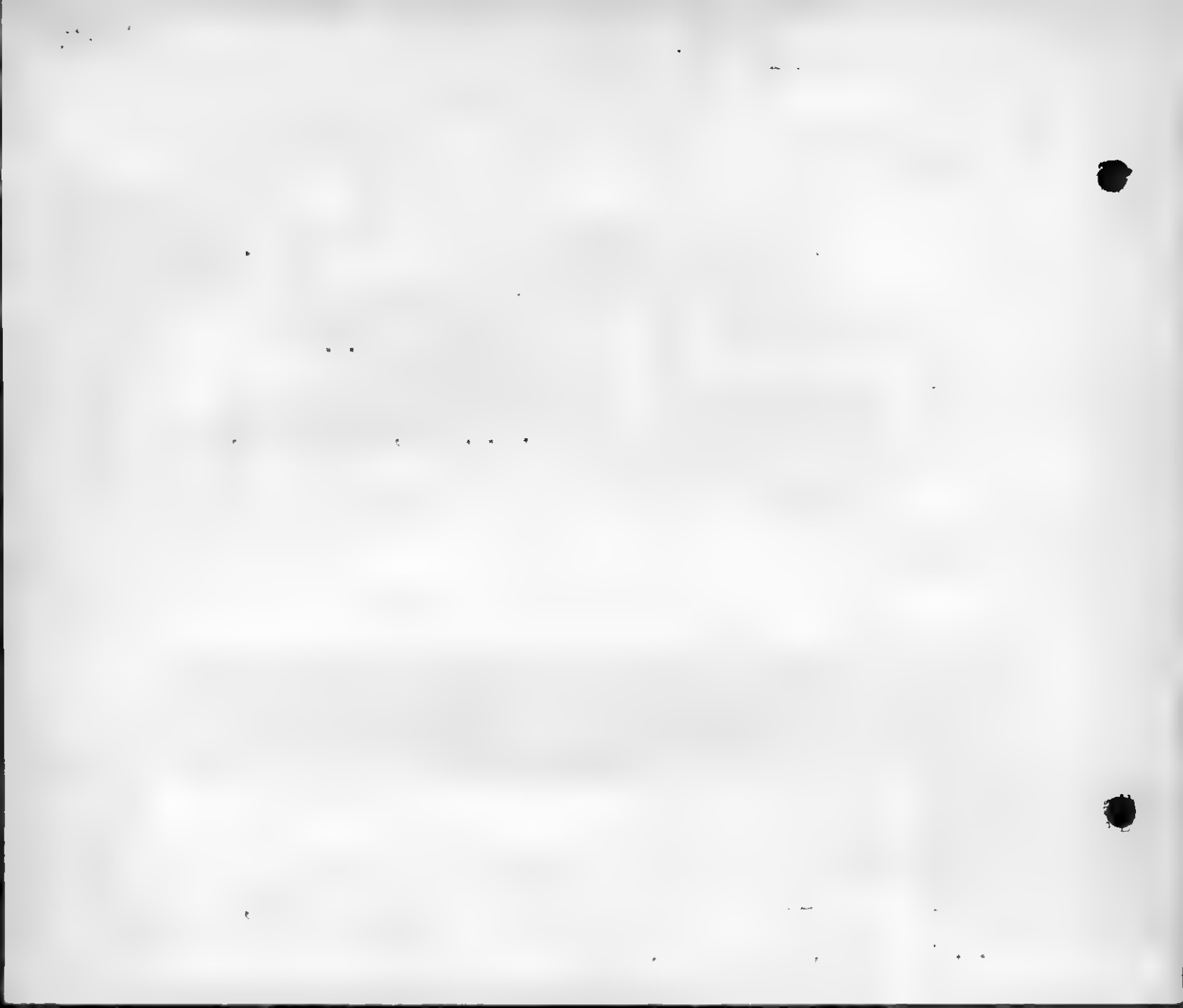
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13838 CERTIFICATE OF DEATH

13826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beaver Brook				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First M. Middle VIOLA Last RATH				4. DATE OF DEATH Month Dec. Day 3 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-2-1878	
9. AGE (In years last birthday) 80 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cornell N.Y.	
12. CITIZEN OF WHAT COUNTRY? At Home				13. FATHER'S NAME William Foulk			
14. MOTHER'S MAIDEN NAME Mary ?				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. J.D. Brown, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) CERE BROVASCULAR ACCIDENT DUE TO (c) ASCVD						INTERVAL BETWEEN ONSET AND DEATH 2 HRS 10 YRS-	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to 12-3 , 1958, that I last saw the deceased alive on 12-3-58 , 19, and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ELICOTT CITY DATE SIGNED 12-4-58							
ACTUAL SIGNATURE P. Thorpe M.D.				PHYSICIAN'S NAME (Type) PETER V. THORPE MD M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DEC 8 58		24b. REGISTRAR'S SIGNATURE Carroll S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

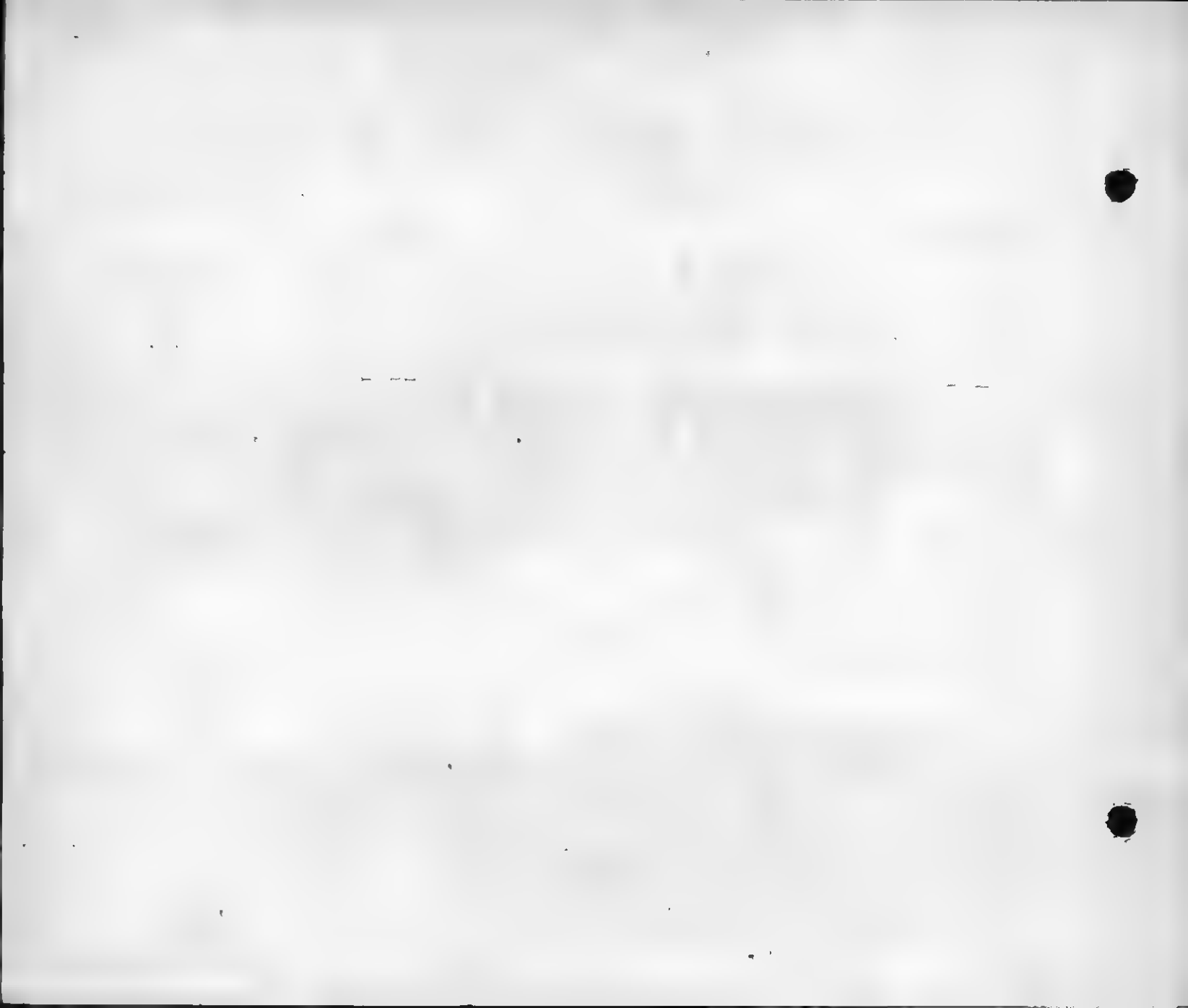
13839 CERTIFICATE OF DEATH

13827

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS 2037 Hollins St. Balto 23,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle W Last Rottmann		4. DATE OF DEATH Month December Day 25 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 15, 1883
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Botteler	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Rottmann	
14. MOTHER'S MAIDEN NAME Margaret		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 216 01 4522		17. INFORMANT Mrs. Veronica Rottmann, 2037 Hollins St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident (thrombosis) DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 4 days years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Brain Disorder			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 14 , 19 58 , to Dec 25 , 19 58 , that I last saw the deceased alive on December , 19 58 , and that death occurred at 7:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Stephen Lee Magness M.D. Taylor Manor Hospital		PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Taylor Manor Hospital, Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/29/58	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore 29, Md
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE DEC 29 '58	24b. REGISTRAR'S SIGNATURE Colin E. Kraw

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13840 CERTIFICATE OF DEATH

13828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel R.F.D.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel R.F.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>LUCILLE</u> Middle <u>RUSTIN</u> Last <u>RUSTIN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Mary's Co Md</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John Woodland</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Emelyn Snowden Laurel R.F.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CORONARY ATHEROSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-17</u> , 19 <u>58</u> , to <u>12-2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-2</u> , 19 <u>58</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas R. Mazzocco</u> M.D.		ADDRESS (Street, city or town, state) <u>320 Montgomery</u> DATE SIGNED <u>12-28</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS R. MAZZOCCO</u>		<u>LAUREL, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgely Selby</u>		ADDRESS <u>1200 Snowden Place</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



13841 18' CERTIFICATE OF DEATH

13829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cooksville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cooksville md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cooksville At home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle A. Last WEBB				4. DATE OF DEATH Month Dec Day 19th Year 1958			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH: 4/13/1869	
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR: Months 8 Days 19 Hours 15 Min.		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY at home			
13. FATHER'S NAME John S. Engel				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. -			
17. INFORMANT Mr Harry S. Engel				Address Cooksville md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 490x (b) Cardiac decompensation DUE TO (c) Heart disease INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days 3 weeks 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sacro-iliac bed sores, extensive							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-30 , 1958, to 12-19 , 1958, that I last saw the deceased alive on 12-19 , 1958, and that death occurred at 8:20 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Bertrand R. Gail				ADDRESS (Street, city or town, state) SYKESVILLE Md.			
PHYSICIAN'S NAME (Type) Bertrand R. Gail				DATE SIGNED 12/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/58		22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) 3801 Frederick - Ave	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowanston				ADDRESS 90 Hallins St.		24a. REC'D BY REGISTRAR DATE DEC 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		RACE [Faint handwritten race]	
PLACE OF BIRTH [Faint handwritten place]		DATE OF BIRTH [Faint handwritten date]	
PLACE OF DEATH [Faint handwritten place]		DATE OF DEATH [Faint handwritten date]	
CAUSE OF DEATH [Faint handwritten cause]			
MANNER OF DEATH [Faint handwritten manner]			
SIGNATURE OF PHYSICIAN [Faint handwritten signature]			
SIGNATURE OF REGISTRAR [Faint handwritten signature]			
SIGNATURE OF WITNESS [Faint handwritten signature]			

